LA County Department of Health Services

PHLN Year 2 Project Aim

Food Insecurity AIM Statement:

We will effectively address high-priority social needs of our patients to improve clinical outcomes by ***linking at least 25%*** of patients seen in Phase 1 Primary Care sites who screen positive for ***food insecurity*** to appropriate resources by December 31, 2019.

Measures for Success

Process:

Percent of total Phase 1 Site staff trained on Food Insecurity

Percent of total Phase 1 Site nursing/social work staff trained on workflows

Percent of patients seen in Phase 1 Sites (Primary Care) that are:

- Screened for FI
- Screened positive for FI
- Referred to resources
- Follow attempt was made

Outcomes:

Percent of patients who screened positive that were *linked* to resources

Percent of patients screened and enrolled in Cal-Fresh

Percent of patients linked to resources whose needs were met

Balance:

Cycle time

Patient experience data

Changes

Tested Changes

- Observations conducted of local workflows for food insecurity screening and referral at Phase 1 sites.
- A "pop-up" window was developed and tested for documenting follow-up actions for positive screens.
- We are creating a "toolkit" based on the observations and testing which will include screening/referral/ linkage workflows, local food resources, scripts for clinic staff, guidelines for EMR documentation, etc.

Implemented Changes

- The Hunger Vital Sign was built in our EMR in the nursing intake under a new "Social Needs" tab.
- Food insecurity screening initiated at all Phase 1 sites using the Hunger Vital Sign.
- A report to query number of screenings performed and number of positive screens was built.
- A registry was built that lists patients with positive screens.

Using Data for Improvement

- Workflow Observation Tool:

PHLN Food Insecurity Workflow Observation

DATE/TIME:
LOCATION:
CLINIC:
OBSERVER:

Areas of Focus:

1. Information and Data Systems (documentation, referral, spreadsheets, etc.):

2. Planned Care and Delivery (intake, referral, etc.):

3. Patient Engagement:

4. Community Linkages:

Social Work and/or Patient Exit Interview:

General Notes:

Using Data for Improvement

Instructions: Test in Five patients who screen positive for either or both FI Screening questions.
Test/Use with the Paper AdHoc pop-up to populate Column C.
Perform Chart Review and/or patient outreach 2 weeks after positive screen to assess if patient accessed a recommended resource.

Patient	Patient Name	Patient MR #	FI Positive Screen Date	Staff Member acting on Pos Screen	Action for Positive Screen	Linked to Resource after 2 weeks?	Comments (please specify resource from Column F and/or G)

- PDSA testing on patients who screen positive for Food Insecurity

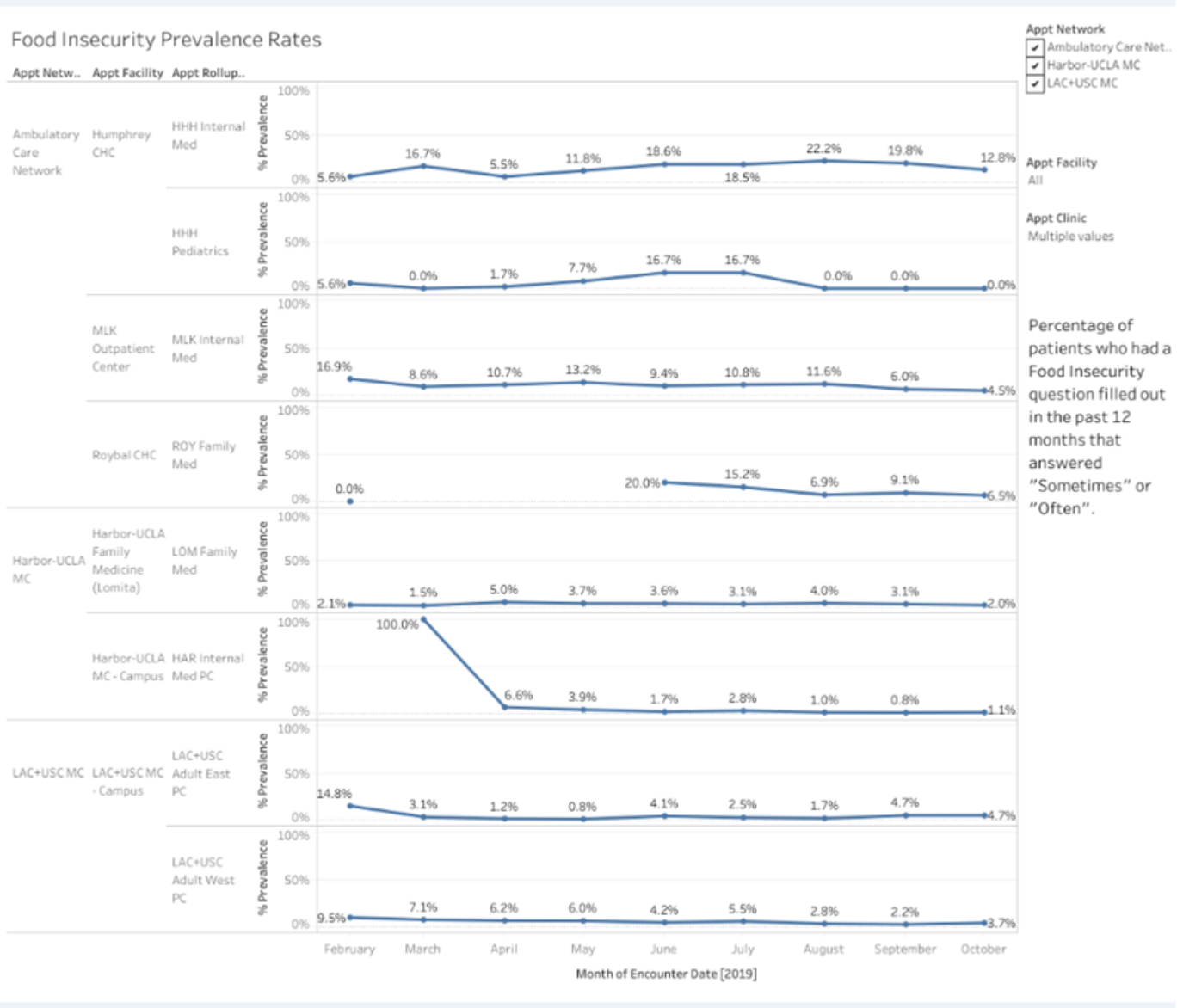
Yes	Patient/Caregiver given handout on local food pantries and/or other community food resources.
No	Patient/Caregiver given CalFresh information sheet.
	PCP and/or Care Manager notified of positive FI screening
	Patient booked with Social Work/ Specialty request to Social Work order placed in ORCHID
	Warm handoff to designated support staff performed.
	Patient referred to Wellness Center.
	Patient declines resources and/or referral for FI resources at this time.
	Other (please specify other or multiple actions in comments)

Using Data for Improvement

- FI Screening Rates by Facility

Using Data for Improvement

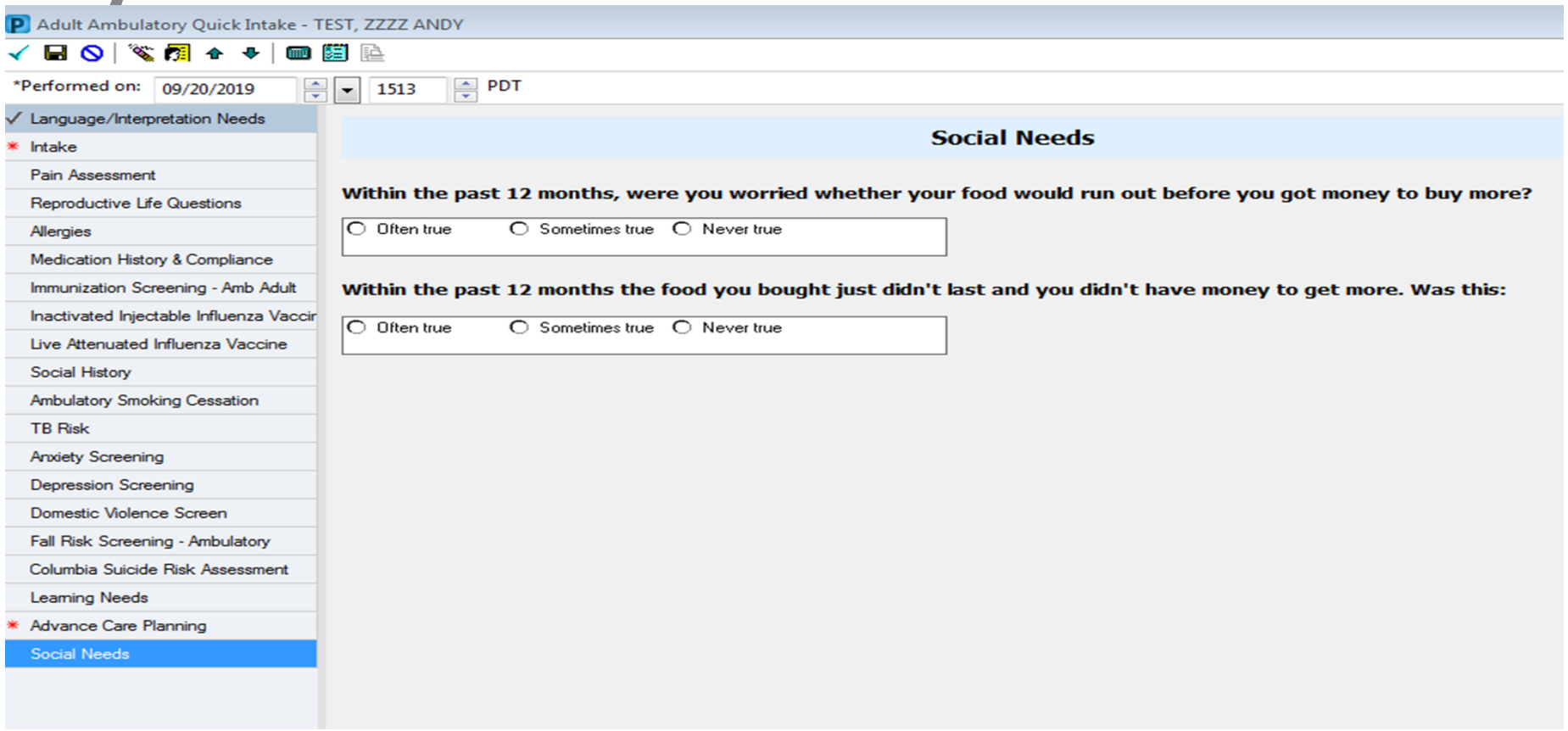
- FI Prevalence Rates by Facility



Strategies for Success

1. Convening leaders from different DHS facilities to develop and vet system-wide best practices
2. Testing with frontline users
3. Intentional planning around the training required for system-wide implementation
4. Ensuring the screening tools, registries, reports, etc. are built and integrated into the EMR

Key Tools & Resources



Hunger Vital Signs integrated into nursing intake

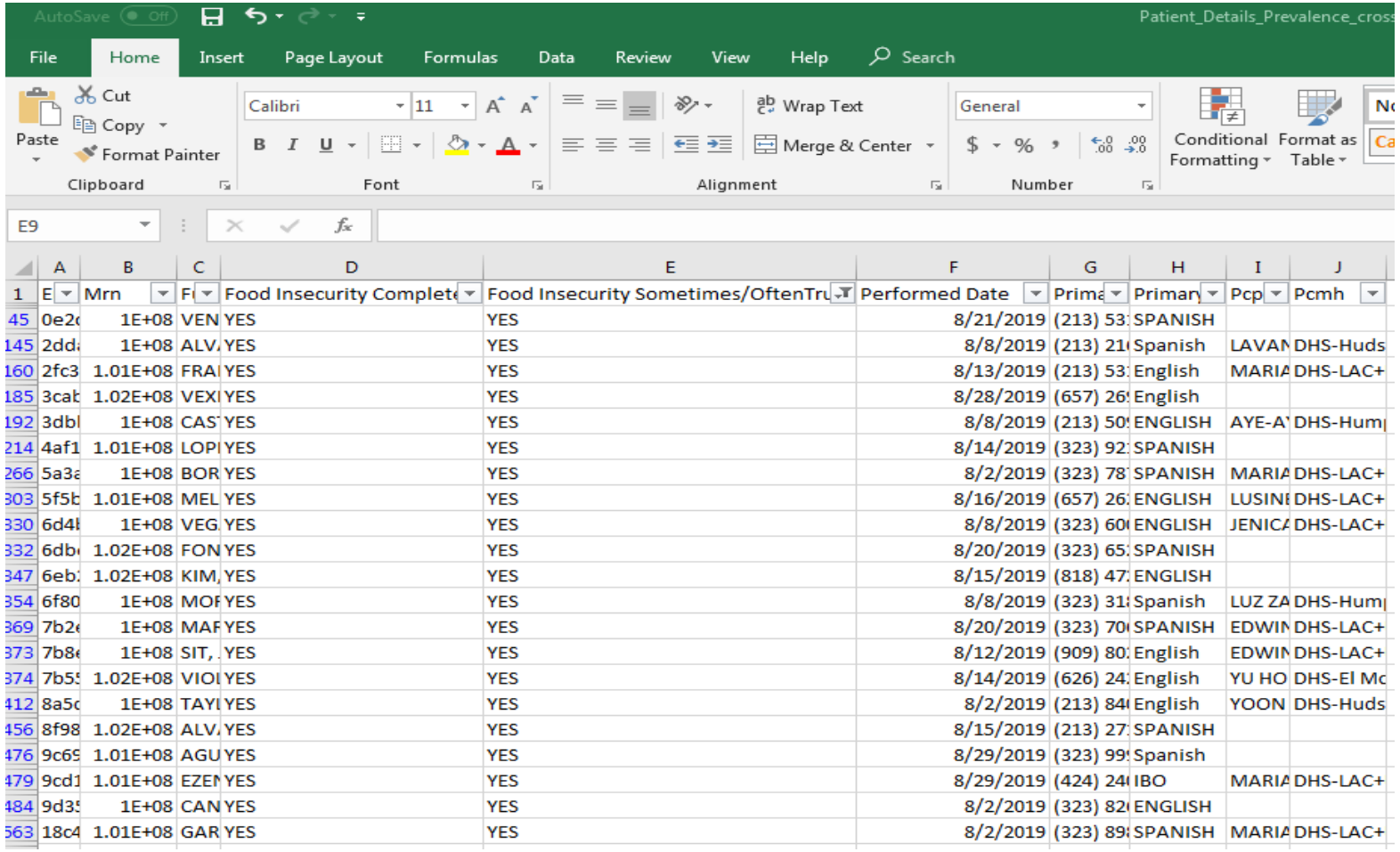
Key Tools & Resources

Patient answers “Yes” to one or both Hunger vital sign Food Insecurity (FI) Screening questions -> ad hoc pops up or dithered window appears in the Intake with the following documentation options:

[ ] Patient/Caregiver given handout on local food pantries and/or other community food resources.
[ ] Patient/Caregiver given CalFresh information sheet.
[ ] PCP and/or Care Manager notified of positive FI screening.
[ ] Patient booked with Social Work/ Specialty request to Social Work order placed in ORCHID.
[ ] Warm handoff to designated support staff performed.
[ ] Patient referred to Wellness Center.
[ ] Patient declines resources and/or referral for FI resources at this time.
[ ] Other: [Free Text Field]

EMR “Pop-up” window drafted to document follow up actions for positive Hunger Vital Sign screens.

Key Tools & Resources



	A	B	C	D	E	F	G	H	I	J
1	E	Mrn	F	Food Insecurity Complete	Food Insecurity Sometimes/OftenTru	Performed Date	Prima	Primary	Pcp	Pcmh
45	0e2c	1E+08	VEN	YES	YES	8/21/2019	(213) 53	SPANISH		
145	2dd	1E+08	ALV	YES	YES	8/8/2019	(213) 21	Spanish	LAVAN	DHS-Huds
160	2fc3	1.01E+08	FRA	YES	YES	8/13/2019	(213) 53	English	MARIA	DHS-LAC+
185	3cab	1.02E+08	VEX	YES	YES	8/28/2019	(657) 26	English		
192	3dbl	1E+08	CAS	YES	YES	8/8/2019	(213) 50	ENGLISH	AYE-A	DHS-Hum
214	4af1	1.01E+08	LOP	YES	YES	8/14/2019	(323) 92	SPANISH		
266	5a3a	1E+08	BOR	YES	YES	8/2/2019	(323) 78	SPANISH	MARIA	DHS-LAC+
303	5f5b	1.01E+08	MEL	YES	YES	8/16/2019	(657) 26	ENGLISH	LUSINI	DHS-LAC+
330	6d4	1E+08	VEG	YES	YES	8/8/2019	(323) 60	ENGLISH	JENICA	DHS-LAC+
332	6db	1.02E+08	FON	YES	YES	8/20/2019	(323) 65	SPANISH		
347	6eb	1.02E+08	KIM,	YES	YES	8/15/2019	(818) 47	ENGLISH		
354	6f80	1E+08	MOF	YES	YES	8/8/2019	(323) 31	Spanish	LUZ ZA	DHS-Hum
369	7b2	1E+08	MAF	YES	YES	8/20/2019	(323) 70	SPANISH	EDWIN	DHS-LAC+
373	7b8	1E+08	SIT,	YES	YES	8/12/2019	(909) 80	English	EDWIN	DHS-LAC+
374	7b5	1.02E+08	VIO	YES	YES	8/14/2019	(626) 24	English	YU HO	DHS-El Mc
412	8a5c	1E+08	TAY	YES	YES	8/2/2019	(213) 84	English	YOON	DHS-Huds
456	8f98	1.02E+08	ALV	YES	YES	8/15/2019	(213) 27	SPANISH		
476	9c69	1.01E+08	AGU	YES	YES	8/29/2019	(323) 99	Spanish		
479	9cd1	1.01E+08	EZE	YES	YES	8/29/2019	(424) 24	IBO	MARIA	DHS-LAC+
484	9d3	1E+08	CAN	YES	YES	8/2/2019	(323) 82	ENGLISH		
563	18c4	1.01E+08	GAR	YES	YES	8/2/2019	(323) 89	SPANISH	MARIA	DHS-LAC+

Food Insecurity Registry:

List of patients who screened positive for food insecurity by month.

Includes date of screen and contact information.

Current Challenges or Barriers

1. Inconsistent tracking and follow-up of FI positive screens which we are addressing through our efforts

2. Need to continue to promote systemwide adoption of FI screening at intake by nursing

Next Steps

Spreading

- Phase 2 will go-live with Food Insecurity screening in Spring 2020 utilizing the new toolkit.
- New Food Insecurity Report will be used to track monthly screening and prevalence rates for all DHS clinics.
- A standardized workflow using the registry for tracking and follow-up on positive screens will be developed.

Sustaining

- Identify and help support sites that have low rates of screening.
- Further identify community resources and enhance our ability to link patients to these resources..
- Celebrate successes and best practices!